FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041228

Facility Name: ROYAL HEIGHTS NURSING & REHAB CENTER LLC

Address: 900 ROYAL HEIGHTS RD (Number) BELLEVILLE (City) 62226 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 235-6133 **Fax #** (618) 235-9860

IDPA ID Number: 371347517001

Date of Initial License for Current Owners: 10/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) EDWARD N. SLACK, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	234	Skilled (SNF)	234	85,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	234	TOTALS	234	85,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,549	142	1,384	5,075	8
9	SNF/PED					9
10	ICF	42,111	1,596	142	43,849	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,660	1,738	1,526	48,924	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.28%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 1,203

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB Cl # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	235,330	19,860	5,869	261,059		261,059		261,059			1
2	Food Purchase		297,636		297,636	(10,016)	287,620	(106)	287,515			2
3	Housekeeping	244,582	15,872		260,454		260,454		260,454			3
4	Laundry	75,635	12,963		88,598		88,598		88,598			4
5	Heat and Other Utilities			132,437	132,437		132,437		132,437			5
6	Maintenance	205,949	14,459	72,579	292,987		292,987	(14,705)	278,282			6
7	Other (specify):*											7
8	**TOTAL General Services**	761,496	360,790	210,885	1,333,171	(10,016)	1,323,155	(14,811)	1,308,345			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000	(3,000)	5,000			9
10	Nursing and Medical Records	1,289,769	130,352	5,390	1,425,511		1,425,511	10,755	1,436,266			10
10a	Therapy	41,801	1,312	11,310	54,423		54,423		54,423			10a
11	Activities	82,914	3,082	1,669	87,665		87,665		87,665			11
12	Social Services	133,435		19,388	152,823		152,823		152,823			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							2,498	2,498			15
16	**TOTAL Health Care and Programs**	1,547,919	134,746	45,757	1,728,422		1,728,422	10,253	1,738,675			16
	C. General Administration											
17	Administrative	55,324		266,667	321,991		321,991	(128,563)	193,428			17
18	Directors Fees											18
19	Professional Services			123,171	123,171		123,171	5,508	128,679			19
20	Dues, Fees, Subscriptions & Promotions			54,352	54,352		54,352	(13,811)	40,541			20
21	Clerical & General Office Expenses	93,757	38,232	170,441	302,430		302,430	(77,332)	225,098			21
22	Employee Benefits & Payroll Taxes			377,007	377,007	10,016	387,023		387,023			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,615	1,615		1,615	584	2,199			24
25	Other Admin. Staff Transportation			8,259	8,259		8,259	5,071	13,330			25
26	Insurance-Prop.Liab.Malpractice			290,283	290,283		290,283	427	290,710			26
27	Other (specify):*							16,907	16,907			27
28	**TOTAL General Administration**	149,081	38,232	1,291,795	1,479,108	10,016	1,489,124	(191,208)	1,297,915			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,458,496	533,768	1,548,437	4,540,701		4,540,701	(195,766)	4,344,935			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC #0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			45,087	45,087		45,087	105,101	150,188			30
31	Amortization of Pre-Op. & Org.							14,459	14,459			31
32	Interest			30,144	30,144		30,144	208,435	238,579			32
33	Real Estate Taxes			87,238	87,238		87,238	22	87,260			33
34	Rent-Facility & Grounds			281,463	281,463		281,463	(272,384)	9,079			34
35	Rent-Equipment & Vehicles			18,516	18,516		18,516	3,587	22,103			35
36	Other (specify):*							47,887	47,887			36
37	TOTAL Ownership			462,448	462,448		462,448	107,106	569,554			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,918	23,059	77,977		77,977	(7,495)	70,482			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,115	128,115		128,115		128,115			42
43	Other (specify):*			6,386	6,386		6,386	(6,386)	0			43
44	TOTAL Special Cost Centers		54,918	157,560	212,478		212,478	(13,881)	198,597			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,458,496	588,686	2,168,445	5,215,627		5,215,627	(102,541)	5,113,086			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,684	30		9
10	Interest and Other Investment Income	(94)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(106)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(845)	21		18
19	Entertainment	(363)	20		19
20	Contributions	(2,400)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(127,349)	21		24
25	Fund Raising, Advertising and Promotional	(7,495)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,808)	20		28
29	Other-Attach Schedule	(44,448)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (169,223)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	66,682		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 66,682		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (102,541)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
ROYAL HEIGHTS NURSING & REHAB CENTER LLC

ID# 0041228
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (5,076)	21	1
2	PPA- Medical Director	(3,808)	09	2
3	PPA- Pharmacy	(7,495)	39	3
4	Marketing	(6,386)	43	4
5	Public Relations	(70)	20	5
6	Bank Charge	(2,464)	21	6
7	R & M Capitze	(14,705)	06	7
8	Finance Charge	(5,106)	32	8
9	Bank Charge-Building	(146)	21	9
10				10
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100				100
101	Total	(44,448)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(106)											(106)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(14,705)											(14,705)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(14,811)											(14,811)	8
	B. Health Care and Programs													
9	Medical Director	(3,000)											(3,000)	9
10	Nursing and Medical Records			10,755									10,755	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			2,498									2,498	15
16	**TOTAL Health Care and Programs**	(3,000)		13,253									10,253	16
	C. General Administration													
17	Administrative			(128,563)									(128,563)	17
18	Directors Fees													18
19	Professional Services			5,508									5,508	19
20	Fees, Subscriptions & Promotions	(14,137)		326									(13,811)	20
21	Clerical & General Office Expenses	(135,879)	146	58,402									(77,332)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			584									584	24
25	Other Admin. Staff Transportation			5,071									5,071	25
26	Insurance-Prop.Liab.Malpractice			427									427	26
27	Other (specify):*			16,907									16,907	27
28	**TOTAL General Administration**	(150,016)	146	(41,338)									(191,208)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(167,827)	146	(28,085)									(195,766)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	17,684	86,548	869									105,101	30
31	Amortization of Pre-Op. & Org.		14,459										14,459	31
32	Interest	(5,200)	213,128	506									208,435	32
33	Real Estate Taxes			22									22	33
34	Rent-Facility & Grounds		(281,463)	9,079									(272,384)	34
35	Rent-Equipment & Vehicles			3,587									3,587	35
36	Other (specify):*		47,887										47,887	36
37	TOTAL Ownership	12,484	80,559	14,063									107,106	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(7,495)											(7,495)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(6,386)											(6,386)	43
44	TOTAL Special Cost Centers	(13,881)											(13,881)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(169,223)	80,704	(14,022)									(102,541)	45

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED				
				SEE ATTACHED		
				BELLEVILLE HEALTHCARE		BUILDING
				PROPERTIES	BELLEVILLE	PARTNERSHIP

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 281,463	BELLEVILLE HEALTHCARE PROPERTIES	100.00%	$	$ (281,463)	1
2	V	32	Interest Income	854	BELLEVILLE HEALTHCARE PROPERTIES	100.00%		(854)	2
3	V								3
4	V	31	Amort. Loan		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	14,459	14,459	4
5	V	21	Bank Charge		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	146	146	5
6	V	30	Depreciation		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	86,548	86,548	6
7	V	36	Insurance		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	47,887	47,887	7
8	V	32	Interest Expense		BELLEVILLE HEALTHCARE PROPERTIES	100.00%	213,982	213,982	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 282,317			$ 363,022	$ * 80,704	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSE CONSULTANT	$	HEALTHCARE MNGMNT. ASSOC.	100.00%	$ 10,755	$ 10,755	15
16	V	15	HEALTH CARE EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,498	2,498	16
17	V	17	ADMIN. SAL.-NON OWNER		HEALTHCARE MNGMNT. ASSOC.	100.00%	39,621	39,621	17
18	V	19	PROFESSIONAL FEES		HEALTHCARE MNGMNT. ASSOC.	100.00%	5,508	5,508	18
19	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE MNGMNT. ASSOC.	100.00%	326	326	19
20	V	21	CLERICAL & GENERAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	48,872	48,872	20
21	V	24	SEMINAR		HEALTHCARE MNGMNT. ASSOC.	100.00%	584	584	21
22	V	25	TRAVEL		HEALTHCARE MNGMNT. ASSOC.	100.00%	5,071	5,071	22
23	V	26	INSURANCE		HEALTHCARE MNGMNT. ASSOC.	100.00%	427	427	23
24	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	12,814	12,814	24
25	V	30	DEPRECIATION		HEALTHCARE MNGMNT. ASSOC.	100.00%	869	869	25
26	V	34	OFFICE SPACE		HEALTHCARE MNGMNT. ASSOC.	100.00%	9,079	9,079	26
27	V	32	INTEREST		HEALTHCARE MNGMNT. ASSOC.	100.00%	506	506	27
28	V	33	REAL ESTATE TAXES		HEALTHCARE MNGMNT. ASSOC.	100.00%	22	22	28
29	V	35	EQUIPMENT RENTAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	3,587	3,587	29
30	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	9,530	9,530	30
31	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,055	1,055	31
32	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%			32
33	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%			33
34	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	12,826	12,826	34
35	V	17	ADMIN. SALARY - D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	15,657	15,657	35
36	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,279	1,279	36
37	V	27	EMP. BEN.-D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,759	1,759	37
38	V	17	MANAGEMENT FEE	196,667	HEALTHCARE MNGMNT. ASSOC.	100.00%		(196,667)	38
39	Total			$ 196,667			$ 182,645	$ * (14,022)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB C # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ERIC ROTHNER	RELATIVE	ADMIN	0	SEE ATTACH	0.78	1.08%	MGT FEES	$ 32,200	17-3	1
2	MARK SUISSA	OWNER	ADMIN	42.32%	SEE ATTACH	16.59	27.70%	MGT FEES	32,200	17-3	2
3	MARK SUISSA	OWNER	ADMIN	42.32%	SEE ATTACH	16.59	27.70%	ALLOC HMA	12,826	17-7	3
4	DAVID ARYEH	OWNER	ADMIN	4.70%	SEE ATTACH	10.23	14.20%	MGT FEES	5,600	17-3	4
5	DAVID ARYEH	OWNER	ADMIN	4.70%	SEE ATTACH	10.23	14.20%	ALLOC HMA	15,657	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 98,483		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HEALTHCARE MNGMNT. ASSOC.
Street Address: 1401 S. BRENTWOOD BOULEVARD
City / State / Zip Code: BRENTWOOD, MO. 63144
Phone Number: (314) 963-7570
Fax Number: (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSE CONSULTANT	ILL. & MO. PAT. DAYS	291,047	6	$ 63,981	$ 63,981	48,924	$ 10,755	1
2	15	HEALTH CARE EMPLOYEE BE	ILL. & MO. PAT. DAYS	291,047	6	14,862		48,924	2,498	2
3	17	ADMIN. SAL.-NON OWNER	ILL. & MO. PAT. DAYS	291,047	6	235,701	235,701	48,924	39,621	3
4	19	PROFESSIONAL FEES	ILL. & MO. PAT. DAYS	291,047	6	32,764		48,924	5,508	4
5	20	DUES, SUBSCRIPTIONS	ILL. & MO. PAT. DAYS	291,047	6	1,941		48,924	326	5
6	21	CLERICAL & GENERAL	ILL. & MO. PAT. DAYS	291,047	6	290,735	211,448	48,924	48,872	6
7	24	SEMINAR	ILL. & MO. PAT. DAYS	291,047	6	3,475		48,924	584	7
8	25	TRAVEL	ILL. & MO. PAT. DAYS	291,047	6	30,170		48,924	5,071	8
9	26	INSURANCE	ILL. & MO. PAT. DAYS	291,047	6	2,542		48,924	427	9
10	27	EMPLOYEE BENEFITS	ILL. & MO. PAT. DAYS	291,047	6	76,229		48,924	12,814	10
11	30	DEPRECIATION	ILL. & MO. PAT. DAYS	291,047	6	5,169		48,924	869	11
12	34	OFFICE SPACE	ILL. & MO. PAT. DAYS	291,047	6	54,010		48,924	9,079	12
13	32	INTEREST	ILL. & MO. PAT. DAYS	291,047	6	3,011		48,924	506	13
14	33	REAL ESTATE TAXES	ILL. & MO. PAT. DAYS	291,047	6	131		48,924	22	14
15	35	EQUIPMENT RENTAL	ILL. & MO. PAT. DAYS	291,047	6	21,338	34,464	48,924	3,587	15
16	21	CLERICAL SALARIES	ILL. PAT. DAYS	176,918	4	34,464		48,924	9,530	16
17	27	EMP. BEN. GEN. & ADMIN.	ILL. PAT. DAYS	176,918	4	3,816		48,924	1,055	17
18	21	CLERICAL SALARIES	DIRECT		1	24,711	24,711			18
19	27	EMPLOYEE BENEFITS	DIRECT		1	2,776				19
20	17	ADMIN. SALARY - M. SUISSA	AVG. HOURS WORKED	60	6	46,381	46,381	17	12,826	20
21	17	ADMIN. SALARY - D. ARYEH	AVG. HOURS WORKED	37	4	56,621	56,621	10	15,657	21
22	27	EMP. BEN.-M. SUISSA	AVG. HOURS WORKED	60	6	4,626		17	1,279	22
23	27	EMP. BEN.-D. ARYEH	AVG. HOURS WORKED	37	4	6,361		10	1,759	23
24										24
25	TOTALS					$ 1,015,815	$ 673,306		$ 182,645	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB C] # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CIB BANK		X	MORTGAGE	$22,387.00	06/01/01	$	$ 4,680,795			$ 213,982	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CORUS BANK		X	LINE OF CREDIT	6/1/2001			496,615			24,288	6
7	ASSURANCE		X	INSURANCE FINANCING							750	7
8												8
9	TOTAL Facility Related				$59,430.00		$	$ 5,177,410			$ 239,020	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(442)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (442)	14
15	TOTALS (line 9+line14)						$	$ 5,177,410			$ 238,578	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 47,887 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CE! # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (94)	1
2	Allocation from HMA	X									506	2
3											(854)	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (442)	21

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	82,958	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	83,862	2
3. Under or (over) accrual (line 2 minus line 1).	$	904	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	86,356	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	87,260	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	72,409	8
1998	75,485	9
1999	80,089	10
2000	78,978	11
2001	83,840	12

2002 TAX *1.03 (ESTIMATED INCREASE)= 83,840.70*1.03= $86,356

ALLOCATION FROM HMA $ 22

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROYAL HEIGHTS NURSING & REHAB CENTER LLC COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0041228

CONTACT PERSON REGARDING THIS REPORT Steve Lavemda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-0-400-007	LONG TERM PROPERTY	$ 83,840.70	$ 83,840.70
2.	Allocation from HMA		$	$ 22.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,840.70	$ 83,862.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROYAL HEIGHTS NURSING & REHAB CENTER LLC COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0041228

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,378 B. General Construction Type: Exterior BRICK Frame BLOCK Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 90,801
2. Number of Years Over Which it is Being Amortized: 7 YEARS
3. Current Period Amortization: 14,459
4. Dates Incurred:

Nature of Costs: HUD AND OTHER LOAN COSTS
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1995	$ 237,505	1
2					2
3	TOTALS			$ 237,505	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	28,299		20	1,416	1,416	8,075	9
10	Various			1997	10,691		20	534	534	3,064	10
11	Various			1998	102,789		20	5,141	5,141	23,223	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,172,128	55,696		70,069	14,373	508,000	68
69	Financial Statement Depreciation			6,915			(6,915)		69
70	TOTAL (lines 4 thru 69)		$ 2,313,907	$ 62,611		$ 77,160	$ 14,549	$ 542,362	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,313,907	$ 62,611		$ 77,160	$ 14,549	$ 542,362	1
2	BLINDS	1999	818		20	41	41	164	2
3	CLOSET DOORS	1999	751		20	38	38	149	3
4	WALLPAPER	1999	608		20	30	30	120	4
5	LOBBY WALLPAPER	1999	645		20	32	32	120	5
6	BATHROOM WALLPAPER	1999	514		20	26	26	95	6
7	WALLPAPER	1999	1,425		20	71	71	254	7
8	BIRCH WOOD DOOR	1999	676		20	34	34	122	8
9	NURSE WALLSTATION	1999	930		20	47	47	184	9
10	DRAPERIES	1999	916		20	46	46	169	10
11	LOBBY TILES	1999	4,912		20	246	246	820	11
12	INSTALL TILE	1999	1,125		20	56	56	187	12
13	A/C UNIT	1999	719		20	36	36	129	13
14	A/C UNITS	1999	2,540		20	127	127	434	14
15	A/C UNIT	1999	1,905		20	95	95	317	15
16	ELECTRICAL CIRCUITS	1999	2,447		20	122	122	417	16
17	ELECTRICALCIRCUITS	1999	1,530		20	77	77	263	17
18	SKOKING ROOM	1999	26,516		20	1,326	1,326	2,652	18
19	WALLPAPER	2000	10,150		20	508	508	1,312	19
20	WALLPAPER	2000	9,432		20	472	472	1,219	20
21	DRAPERIES	2000	11,232		20	562	562	1,452	21
22	AUTO DOOR LOCKS	2000	624		20	31	31	72	22
23	AIR CONDITIONER	2000	2,193		20	110	110	293	23
24	WALLCOVERINGS	2001	29,475		20	1,474	1,474	2,702	24
25	ROOFING	2001	15,595		20	780	780	1,430	25
26	WALLCOVERINGS	2001	5,306		20	265	265	464	26
27	WALLCOVERINGS	2001	1,530		20	77	77	141	27
28	ELECTRICAL	2001	3,638		20	182	182	319	28
29	WANDERGUARD	2001	612		20	31	31	36	29
30	WALL AC UNIT	2001	1,462		20	73	73	140	30
31	STORAGE SHED	2001	800		20	40	40	63	31
32	PHONE SYSTEM	2002	9,974		20	665	665	665	32
33	ELEVATOR	2002	12,400		20	362	362	362	33
34	TOTAL (lines 1 thru 33)		$ 2,477,307	$ 62,611		$ 85,242	$ 22,631	$ 559,628	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,477,307	$ 62,611		$ 85,242	$ 22,631	$ 559,628	1
2	ALARM SYSTEM	2002	3,404		20	199	199	199	2
3	VINYL FLOORING	2002	1,976		20	33	33	33	3
4	SECURITY CAMERAS	2002	6,328		20	105	105	105	4
5	BATH FIXTURES	2002	2,962		20	99	99	99	5
6	FAN	2002	808		20	34	34	34	6
7	ROOF VENTILATOR	2002	4,717		20	118	118	118	7
8	BATHROOM VINYL FLOORING	2002	3,426		20	43	43	43	8
9	SIGNS	2002	950		20	8	8	8	9
10	PHONE SYSTEM	2002	1,467		20	6	6	6	10
11	PAINTING AND WALLCOVERING	2002	7,335		20	31	31	31	11
12	ROOF REPAIRS	2002	2,850		20	12	12	12	12
13	INTERIOR DECORATING	2002	1,531		20	64	64	64	13
14	HORN STROB	2002	972		20	57	57	57	14
15	WATER HEATER	2002	5,590		20	559	559	559	15
16	COMPRESSOR	2002	609		20	21	21	21	16
17	COMPRESSOR	2002	1,671		20	93	93	93	17
18	WATER PUMP	2002	1,088		20	54	54	54	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,524,991	$ 62,611		$ 86,778	$ 24,167	$ 561,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	234		1995	1975	$ 2,172,128	$ 55,696	39	$ 70,069	$ 14,373	$ 508,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,172,128	$ 55,696		$ 70,069	$ 14,373	$ 508,000	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 574,058	$ 46,047	$ 57,285	$ 11,238	10	$ 386,579	71
72	Current Year Purchases	79,155	19,085	3,574	(15,511)	10	3,574	72
73	Fully Depreciated Assets	14,879				10	14,879	73
74								74
75	TOTALS	$ 668,092	$ 65,132	$ 60,859	$ (4,273)		$ 405,032	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FORD VAN	2002	$ 23,800	$ 4,760	$ 2,550	$ (2,210)	5	$ 2,550	76
77										77
78										78
79										79
80	TOTALS			$ 23,800	$ 4,760	$ 2,550	$ (2,210)		$ 2,550	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,454,388	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	132,503	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	150,187	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	17,684	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	968,746	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	ALLOCATION-HMA				9,079			5
6								6
7	TOTAL				$ 9,079 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,495 Description: SEE ATTACH
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2000 VOLVO(S80)	$ 626.73	$ 7,608	17
18					18
19					19
20					20
21	TOTAL		$ 626.73	$ 7,608	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 7,011	$		$ 7,011	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,048			3,048	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			13,000			13,000	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				45,670		45,670	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						9,248		9,248	13
14	TOTAL			$		$ 23,059	$ 54,918		$ 77,977	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 71,639	$ 73,813	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	181,601	181,601	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	212,956	213,783	6
7	Other Prepaid Expenses	909	909	7
8	Accounts Receivable (owners or related parties)	378,407	2,581,841	8
9	Other(specify): See Supplemental Schedule	2,485	523,171	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 847,997	$ 3,575,118	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,505	13
14	Buildings, at Historical Cost		2,172,128	14
15	Leasehold Improvements, at Historical Cost	268,901	268,901	15
16	Equipment, at Historical Cost	274,639	742,639	16
17	Accumulated Depreciation (book methods)	(174,768)	(1,044,243)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		90,549	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 368,772	$ 2,467,479	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,216,769	$ 6,042,597	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 987,608	$ 987,609	26
27	Officer's Accounts Payable	573,275	573,275	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	496,615	496,615	29
30	Accrued Salaries Payable	18,125	18,125	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,000	3,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)	86,356	86,356	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,886	4,886	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	16,990	16,990	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,186,855	$ 2,186,856	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,680,795	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,680,795	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,186,855	$ 6,867,651	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (970,086)	$ (825,054)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,216,769	$ 6,042,597	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 16,344	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 16,344	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(986,430)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (986,430)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (970,086)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTE # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,123,695	1
2	Discounts and Allowances for all Levels	78,097	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,201,792	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	11,880	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 11,880	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,329	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,329	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	94	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 94	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,102	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,102	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,229,197	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,333,171	31
32	Health Care	1,728,422	32
33	General Administration	1,479,108	33
	B. Capital Expense		
34	Ownership	462,448	34
	C. Ancillary Expense		
35	Special Cost Centers	84,363	35
36	Provider Participation Fee	128,115	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,215,627	40
41	**Income before Income Taxes (line 30 minus line 40)****	(986,430)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (986,430)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,873	1,873	$ 36,148	$ 19.30	1
2	Assistant Director of Nursing	367	367	7,074	19.30	2
3	Registered Nurses	7,649	7,649	133,254	17.42	3
4	Licensed Practical Nurses	33,499	33,499	489,423	14.61	4
5	Nurse Aides & Orderlies	68,116	68,116	561,953	8.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,036	4,039	41,801	10.35	8
9	Activity Director	1,903	1,903	13,476	7.08	9
10	Activity Assistants	9,808	9,808	69,438	7.08	10
11	Social Service Workers	13,929	13,929	133,435	9.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,052	33,052	235,330	7.12	15
16	Dishwashers					16
17	Maintenance Workers	26,472	26,472	205,949	7.78	17
18	Housekeepers	43,598	43,598	244,582	5.61	18
19	Laundry	14,744	14,744	75,635	5.13	19
20	Administrator	2,448	2,448	55,324	22.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,666	9,666	93,757	9.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,564	8,564	61,917	7.23	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	279,721	279,724	$ 2,458,496 *	$ 8.79	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	173	$ 5,869	01-03	35
36	Medical Director	MONTHLY	8,000	09-03	36
37	Medical Records Consultant	32	1,120	10-03	37
38	Nurse Consultant	86	3,020	10-03	38
39	Pharmacist Consultant	MONTHLY	1,250	10-03	39
40	Physical Therapy Consultant	65	4,114	10a-03	40
41	Occupational Therapy Consultant	59	3,834	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	53	3,362	10a-03	43
44	Activity Consultant	MONTHLY	1,669	11-03	44
45	Social Service Consultant	305	19,388	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	773	$ 51,626		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LL(# 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cythia Anderson (9/02-12/02)	Administrator	0	$ 28,200
Clara Rich (1/02-8/02)	Administrator	0	27,124
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,324

B. Administrative - Other

Description	Amount
Management Fees-Eric Rothner	$ 32,200
Management Fees-Mark Suissa	32,200
Management Fees-David Aryeh	5,600
HMA-Office Expense	196,667
TOTAL (agree to Schedule V, line 17, col. 3)	$ 266,667
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planner	Unemployment Consult	$ 2,566
FR & R	Accounting	20,552
BKD	Accounting	900
Threshold Data	Computer	3,040
CPT Corp	Legal	683
Duane Morris	Legal	93,142
John Rea	Legal	2,369
Deeba Suter Herd	Legal	(80)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 123,171

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 85,469
Unemployment Compensation Insurance	64,487
FICA Taxes	149,009
Employee Health Insurance	45,008
Employee Meals	10,016
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefit	32,484
EE Benefit Plan	551
TOTAL (agree to Schedule V, line 22, col.8)	$ 387,023

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	20,434
Health Care Worker Background Check	
(Indicate # of checks performed 184)	4,210
Alloc. HMA Dues	326
Yellow Page Advertising	3,808
Advertising	7,495
Pulic Relations	70
Dues & Subscriptions	545
Licenses & Fees	15,027
Less: Public Relations Expense	(70)
Non-allowable advertising	(7,495)
Yellow page advertising	(3,808)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,542

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,615
Alloc. Seminar	584
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,199

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ROYAL HEIGHTS NURSING & REHAB CENTER LLC # 0041228 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 128,115
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 10,016 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees